northern health
the northern way of caring

Request to Correct Personal Information

Last Name:_____ First Name:_____ Middle Name:_____

Personal Health Number (PHN):_____ Date of Birth:_____

Address Information

Street, Apt. # PO Box, RR#:_____

City/Town:_____ Province:_____ Country:_____ Postal Code:_____

Telephone Information:

Daytime Phone:_____ Cell Phone:_____ Other Phone:_____

Details Of Personal Information To Be Corrected

Please provide details as to why you think there are errors or omissions concerning your personal information and attach any supporting documentation. Please attach a letter if there is not enough room on this form. (Note that only factual demographic information can be changed in the original record. Requests to change medical information will only be appended to the document in question)

Facility:_____ Date of visit:_____

(Name of the facility where you are requesting the correction)

Add supporting documentation below:

_____

_____

_____

_____

_____

All information contained on this form is collected under the Freedom of Information and Protection of Privacy Act and will be used only for the purpose as outlined in Section 29.

Print Name:_____ **Signature:**_____

Relationship to requestor:_____ **Date:**_____

On completion of this form, please fax or mail it to the Health Information Management Department in the facility you are requesting the correction to your health record on. Please look for the fax number and mailing addresses on the Northern Health website under the "Find a Facility" tab and click on "See all" for more details regarding each facility.

Pursuant to FIPPA, Northern Health has 30 business days to respond to your request.